PRINTED: 05/16/2011 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						O!	MB NO. 0938-0391	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMP	PLETED	
		155520	B. WIN			- 04/20/	2011	
NAME OF		D			ADDRESS, CITY, STATE, ZIP COI	DE DE		
NAME OF	PROVIDER OR SUPPLIE	R	909 FIRST AVE					
	IURSING & REHAB	BILITATION		EVANS	SVILLE, IN47710			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX	·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	PROPRIATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE	
F0000								
	This wisit was fo	or a recertification and	EC	0000	•		+	
			[	0000				
		urvey. This visit included						
	1	n of complaint number						
	IN00088824.							
	Commission would	L INIOOOOOO						
	1 *	ber: IN00088824,						
	1	o deficiencies related to						
	the allegations a	are cited.						
	1	April 12, 13, 14, 15, 18,						
	20, 2011							
	Facility Number	r: 000437						
	Provider Number							
	AIM Number:							
	Allyi Number.	1002/37/0						
	Survey Team:							
	Sue Webster, Ri	N TC						
	Diane Hancock,							
	Jodi Meyer, RN							
	4/12/11							
	Amy Wininger,	PN						
		, 4/18, 4/20, 2011						
	7/12, 4/13, 4/14	, 7/10, 7/20, 2011						
	Census Bed Typ	ne.						
	SNF/NF= 17	<b>.</b>						
	NF= 44							
	Total= 61							
	10181-01							
	Census Payor Ty	une:						
	Medicare= 3	ypc.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Medicaid= 54

Event ID:

NNBY11

Facility ID:

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155520		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COME	(X3) DATE SURVEY COMPLETED 04/20/2011	
	PROVIDER OR SUPPLIE		909 FIF	ADDRESS, CITY, STATE, ZIP CO RST AVE VILLE, IN47710	DDE	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIENT REGULATORY OF OTHER STATE OF THE PROPERTY OF THE PROPE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	Quality review con Cathy Emswiller R					

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155520	(X2) MULTIPLE  A. BUILDING  B. WING	O0	(X3) DATE SURVEY COMPLETED 04/20/2011
	ROVIDER OR SUPPLIER		STREE 909 F	ET ADDRESS, CITY, STATE, ZIP CODE FIRST AVE NSVILLE, IN47710	1
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSG DENTIFY OF DEFINITION AND THE PERCENTAGE OF	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIL DEFICIENCY)	
F0157 SS=D	A facility must immoresident; consult wand if known, notifice representative or a when there is an a resident which respotential for requiring significant change mental, or psychosocial status conditions or clinical alter treatment significant conditions or clinical alter treatment significant in the psychosocial status conditions or clinical alter treatment significant in the facility as specified. The facility must a resident and, if known representative or in when there is a change in resident state law or regular paragraph (b)(1) of the facility must resident's legal registerity is legal registerity failed was notified of a pain medication, receiving as need of 1 supplemental	is in either life threatening all complications); a need to inificantly (i.e., a need to sting form of treatment due guences, or to commence a nent); or a decision to ge the resident from the d in §483.12(a).  Iso promptly notify the lown, the resident's legal interested family member ange in room or roommate excified in §483.15(e)(2); or ent rights under Federal or ations as specified in of this section.  Becord and periodically is and phone number of the presentative or interested ew and record review, to ensure a physician resident's use of routine when he was routinely led pain medication, for 1 all sample resident in, in the supplemental	F0157	This facility will ensure the resident, their legal represe and physician are notified oresident(s) routine PRN pair medication administration. A assessment was completed Resident #23 on April 18, 20 the resident's physician was notified and a physician's or was recived on April 19, 20	f the n n n n pain l for 011, s rder

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NNBY11 Facility ID:

000437

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		, DDIG	00	COMPL	ETED
		155520	A. BUI B. WIN	LDING		04/20/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R		1			
00DE N	UDOING A DELLAD	U ITATION		1	RST AVE		
CORE N	URSING & REHAB	ILITATION		EVANS	VILLE, IN47710		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					Lortab 7.5 mg p.o. BID and		
	Finding includes:				7.5 mg p.o. qd to assist in p		
					management. The resident		
	Dumin a imitial to	on 04/12/11 at 1:15			legal representative was not		
	1	ur, on 04/12/11 at 1:15			regarding the resident's cha	-	
	1	erview, RN #1 indicated			medication. All licensed nursely were inserviced on May 6, 2		
	Resident #23 wa	as not interviewable,			on their responsibility in	.011	
	required total as	sistance for care, and was			monitoring and communicat	ina	
	transferred by H	oyer [mechanical] lift.			the use of PRN pain medica		
	,	, L J			to assist in pain managemen		
	The clinical rese	ord of Resident #23 was			The inservices also included		
					importance of notification be	eing	
		18/11 at 10:30 A.M.			provided to the resident, the	ir	
	1	liagnoses included, but			legal representative and the		
	were not limited	to, Alzheimer's disease,			attending physician. A new		
	arthritis, and ost	eoporosis.			management form has beer		
	Í	•			developed along with a quai		
	The most curren	t MDS [Minimum Data			assessment tool and weekly	′	
		-			monitoring tool. Each unit manager will inform the		
	1	, dated 02/24/11,			interdisciplinary team memb	are	
	1	esident #23 was severely			weekly during the at-risk me		
	cognitively impa	aired, had not been on a			of PRN medication use freq		
	scheduled pain i	ned regimen, had received			and explanation. This inforr		
	PRN [as needed	pain medication, and			will assist the resident and t	he	
	there was no pre	sence of pain			IDT members in interventior	is to	
					assist in pain management.	A	
	A Core Dien	datad on 02/15/11 for			review of all medical records		
	1	dated on 02/15/11, for			conducted on April 22, 2011		
		t r/t decreased physical			residents receiving PRN pai	n	
		ility et endurance,"			medication(s). All pain assessments have been rev	iowod	
	indicated, "19.	Monitor for			and updated. It was determ		
	signs/symptoms	of painand take			that no additional residents		
	appropriate action				been negatively affected.A		
					assessment has been comp		
	A Numaira a Decare	raga Nata for the			for each resident receiving r		
	"	ress Note, for the			and/or PRN pain medication	າ by	
	1	od of 02/10/11 to			the MDS Coordinator to mo	nitor	
	1	ted Resident #23 was alert			the frequency of use, the		
	to self, and lack	ed any documentation of			explanation of use, interven	tions	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPL	ETED
		155520	A. BUII B. WIN			04/20/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8					
00051		W.ITATION!			RST AVE		
CORE N	URSING & REHAB	ILITATION		EVANS	VILLE, IN47710		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	pain assessment.		İ		and effectieness. A weekly		
	1				monitoring tool has been		
	In an intervious	with LPN #3, on 04/18/11			developed for each Unit Mar	ager	
		· ·			to thoroughly assess the		
		ne indicated, "The last			frequency, explanation,		
		assessment was March			interventions and effectivene		
	2010. I do the ir	nterview on the new MDS			which will be discussed weel with the IDT members at the	\iy	
	quarterlyHe sa	aid he wasn't in pain when			at-risk meeting. The monitor	ina	
	I interviewed hir	n."			tool will be provided to the	y	
					Director of Nursing for input	as to	
	A Nurging Note	dated 03/16/10 and			the effectiveness. This		
	_				information will be discussed		
	_	ain assessment indicated,			quarterly with the Quality		
		o require prn Lortab			Improvement Committee. The		
	almost daily time	es one dose for bil			MDS Coordinator will update		
	[bilateral] knee p	pain with effective results.			pain assessment and evalua		
	_	monitor for adeq			pain medication use for the la		
	[adequate] level	•			90 days (using the quarterly	paın	
	[adequate] level	or connort.			evaluation form) for effectiveness.The Director of	:	
					Nursing assumes responsibi		
	1	11 MAR [Medication			and wilol monitor weekly thro		
	Administration I	Record] was reviewed, on			the monitoring tool provided	-	
	04/18/11 at 1:00	P.M., and indicated			each Unit Manager. This	-,	
	Resident #23 use	ed Lortab 7.5-500 fifteen			monitoring will become part of	of the	
	times in 24 days				weekly at-risk meeting agend		
	_	A.M. for "pain."			and will be ongoing for the		
		•			remainder of 2011.		
		A.M. and 8:00 P.M. for					
	"lower back pair						
		A.M. for "bilateral knee					
	pain."						
	02/05/11 at 8:00	P.M. for "bilateral knee					
	pain."						
	_	P.M. for "bilateral knee					
		1.1v1. 101 Ullateral Kilee					
	pain."	D. ( )   11: 1					
		P.M. for "rubbing knees					
	moaning."						
	02/12/11 at 8:00	P.M. for "bilateral knee					

'			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155520	A. BUI	LDING	00	COMPL 04/20/2	
		100020	B. WIN			04/20/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
CORE N	URSING & REHABI	ΙΙΤΔΤΙΩΝ		1	RST AVE VILLE, IN47710		
					VILLE, 11477 10		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	pain."	,	-				
	1 *	P.M. for "bilateral knee					
	pain."	1.WI. 101 bilateral kilee					
	1 -	P.M. for "bilateral knee					
	pain."	1.1vi. 101 bilateral knee					
	1 ^	P.M. for "bilateral knee					
	pain."	1.WI. 101 bilateral kilee					
	1 *	A.M. for "bilateral knee					
	pain."	A.W. 101 Ullateral Kilee					
	1 ^	A.M. for "rubbing knees					
		if in pain states 'yeah.'"					
		P.M. for no reason					
	specified.	1 .W. 101 HO ICASOH					
	1 ^	P.M. for "bilateral knee					
	pain."	1.1vi. 101 bilateral knee					
	1 *	P.M. for "bilateral knee					
	pain."	1 .W. 101 Ullateral Kilee					
	pann.						
	The March 2011	MAR was reviewed on					
		P.M. and indicated					
		ed Lortab 7.5-500 fifteen					
	times in 24 days						
	1	A.M. and 8:00 P.M. for					
	bilateral knee pai						
	1	A.M. and 8:00 P.M. for					
	"bilateral knee pa						
	1	A.M. for "knee pain."					
		P.M. for "knee and leg					
	pain."						
	1 ^	P.M. for "knee and leg					
	pain."	<b>U</b>					
	1 ^	P.M. for "knee pain."					
		P.M. for "knee pain."					
		P.M. for "knee pain."					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	A. BUILDING 00			COMPLETED	
		155520	B. WIN	G		04/20/20	011	
NAME OF I	PROVIDER OR SUPPLIER	•		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
				1	RST AVE			
CORE N	URSING & REHABI	LITATION		EVANS	VILLE, IN47710			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	· `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE	
		P.M. for "knee pain."						
		P.M. for "knee pain."						
		A.M. for "rubbing knees						
	and moaning."							
		A.M. for "knee pain."						
		A.M. for "bilateral knee						
	pain."							
		P.M. for "bilateral knee						
	pain."							
		P.M. for "bilateral knee						
	pain."							
	1 ^	MAR was reviewed on						
		P.M. and indicated						
		ed Lortab 7.5-500 eleven						
	times in 15 days							
		A.M. for "moaning						
	loudly suspect pa							
		P.M. for "knee pain."						
		A.M. for "moaning						
	loudly as in pain.	."						
		A.M. for "bilateral knees						
	hurting."							
		5 P.M. for "rubbing knees						
	and moaning."							
	04/06/11 at 4:30	P.M. for "rubbing						
	knees."							
	04/09/11 at 8:00	P.M. for "knee pain."						
	04/10/11 at 8:00	P.M. for "knee pain."						
	04/16/11 at 8:00	A.M. for "bilateral knee						
	pain."							
	04/16/11 at 8:30	P.M. for "moaning, knee						
	pain."							
	04/17/11 at 8:00	P.M. for "moaning						

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/16/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155520	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	li i	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIEF		909 FIF	ADDRESS, CITY, STATE, ZIP C RST AVE VILLE, IN47710	CODE	
CORE N (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR rubbing knees."  A MDS assessm [Licensed Practicat 12:25 P.M. an a worksheet, ind not been experie days, with a hand 'no."  There was no incevaluated the respain medication resident for use of	ent, provided by LPN cal Nurse] #3 on 04/18/11 d identified by LPN #3 as icated Resident #23 had noting pain in the last 5 dwritten notation, "states dident's regular use of prn for pain, or evaluated the of routine pain medication aily use of as needed pain	l		SHOULD BE	(X5) COMPLETION DATE
	Management, pr 04/18/11 at 5:43 resident will be a needs upon admit thereafter utilizing formResident() program/effectivequarterly by the Quarterly the Mit update the pain a	Procedure for Pain ovided by the DoN on P.M., indicated, "All assessed for pain control ission and quarterly ing the Pain Assessment is pain management reness will be evaluated to MDS coordinator. DS coordinator will assessment and review use for the last 90 days."				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155520	B. WING			04/20/2	011
			D. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			909 FIR			
CORE NI	JRSING & REHABI	LITATION			VILLE, IN47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F0272	•	onduct initially and					
SS=D	•	prehensive, accurate,					
	•	oducible assessment of					
	each resident's fur	іспонаї сарасіту.					
	A facility must mak	ke a comprehensive					
		esident's needs, using the					
		ne State. The assessment					
	must include at lea	ast the following:					
		demographic information;					
	Customary routine						
	Cognitive patterns	,					
	Communication;						
	Vision;						
	Mood and behavior Psychosocial well-						
		ng and structural problems;					
	Continence;	ig and structural problems,					
		and health conditions;					
	Dental and nutrition						
	Skin conditions;						
	Activity pursuit;						
	Medications;						
	Special treatments						
	Discharge potentia						
		summary information					
		tional assessment					
	protocols; and	the resident assessment					
		participation in assessment.					
		ation, interview and	FO	272	This facility will conduct initia	lly l	05/20/2011
		e facility failed to ensure		- ' -	and periodically a	<i>•</i>	55/20/2011
		c facility failed to elistife			comprehensive, accurate,		
	a resident was				standardized reproducible		
		provided routine pain			assessment of each resident		
	medication, when	n he was routinely			functional capacity ensuring		
	receiving as need	led pain medication, for 1			each resident is assessed for		
	of 1 supplementa	ll sample resident			provided routing pain medica when they are routinely recei		
	reviewed for pain, in the supplemental				PRN pain medication.The pa	-	
sample of 1. (Resident #23)				assessment was reviewed ar			
	sample of 1. (Re	SidOilt π23 j			updated for Resident #23 on		
						-Te	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NNBY11 Facility ID:

ID: 000437

If continuation sheet

Page 9 of 33

li '		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155520	B. WIN			04/20/2	011
NAME OF	PROVIDER OR SUPPLIE	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	RSTAVE		
CORE N	URSING & REHAB	ILITATION		EVANS	VILLE, IN47710		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
					19, 2011, the resident's phys was notified and a physician		
Finding includes:				order was received for Lortal			
					mg p.o. BID and Mobic 7.5 m		
	During initial to	ur, on 04/12/11 at 1:15			p.o. qd to assist in pain	-5	
	P.M., upon inter	rview RN #1 indicated			management. The resident's	3	
	Resident #23 wa	s not interviewable,			legal representative was noti		
		sistance for care, and was			regarding the resident's char	~	
	1 ^	oyer [mechanical] lift.			medication.All licensed nurse were inserviced on May 6, 2		
		oy •1 [••			on their responsibility in	011	
	The clinical reco	ord of Resident #23 was			monitoring and communicati	ng	
					the use of PRN pain medicat		
	reviewed on 04/18/11 at 10:30 A.M.				to assist in pain managemen		
		iagnoses included, but			new pain assessment form h		
		to, Alzheimer's disease,			been developed along with a quarterly assessment and we		
	arthritis, and ost	eoporosis.			monitoring tool. Each unit	SERIY	
					manager will inform the		
	Resident #23 wa	s observed, on 04/18/11			interdisciplinary team weekly	,	
	at 10:00 A.M., b	eing transferred from a			during the at-risk meeting of		
	wheelchair to a	commode by CNA			medication use frequency ar	ıd	
	[Certified Nursi	ng Assistant] #1 and CNA			explanation of use. This information will assist the res	vidont	
	#2, using a gait b	pelt.			and the IDT members in	naciit	
					interventions to assist in pair	ı	
	The most curren	t MDS [Minimum Data			management.Resident #23 v	vas	
		, dated 02/24/11,			evaluated for physical function	on on	
	1	esident #23 was severely			april 26, 2011 and it was	_	
		aired, had not been on a			determined that he requires a mechanical lift for all transfer		
	1	ned regimen, had received			assist in pain	5	
	1 ^	pain medication, and			reduction/management of		
	there was no pre				bi-lateral knee pain. CNAs w		
	mere was no pre	sence of pani.			inserviced on May 6, 2011 or		
	A Cama Diam	1-4-1 02/15/11 C			importance of the resident ca information sheet and followi		
	1	lated on 02/15/11, for			the resident's plan of care	·· <del>s</del>	
"Self-care deficit r/t decreased physical				designated on the CNA			
	1	ility et endurance,"			assignment sheet.A review of		
	indicated, "19.				medical records was conduc		
	signs/symptoms	of painand take			on April 22, 2011 of all reside	ents	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155520	B. WIN			04/20/2	011
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			RST AVE		
CORF N	URSING & REHAB	II ITATION			VILLE, IN47710		
				<u> </u>			775
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	DATE
IAG		·	+	IAU	receiving PRN pain		DATE
	appropriate action	on."			medication(s). A pain		
					assessment has been compl	eted	
	A Nursing Progr	ess Note, for the			and a thorough review of the		
	observation perio	od of 02/10/11 to			frequency of use of PRN pair	n	
	02/16/11, indicat	ted Resident #23 was alert			medications, the explanation	of	
	to self, and lacke	ed any documentation of			use, interventions and		
	pain assessment.	•			effectiveness. It has been	tional	
	1				determined that four (4) addiresidents had the potential to		
	In an interview v	with LPN #3, on 04/18/11			effected. These residents al		
		ne indicated, "The last			with resident #23 will continu	-	
		-			be monitored weekly by the l	Jnit	
	1 ^	assessment was March			Manager and the Director of		
		nterview on the new MDS			Nursing.A pain assessment h		
		aid he wasn't in pain when			been completed for each res		
	I interviewed hir	n."			receiving routine and/or PRN medication by the MDS	ı paın	
					Coordinator to monitor the		
	A Nursing Note	dated 03/16/10 and			frequency of use, the explana	ation	
	attached to the p	ain assessment indicated,			of use, interventions and		
	_	o require prn Lortab			effectiveness. A weekly		
	1	es one dose for bil			monitoring tool has been		
		pain with effective results.			developed for each Unit man	ager	
		monitor for adeq			to thoroughly assess the frequency, explanation,		
		•			interventions and affectivene	ss	
	[adequate] level	of comfort.			which will be discussed with		
					IDT members weekly during		
	1	11 MAR [Medication			at-risk meeting. The monitor	ing	
	Administration I	Record] was reviewed, on			tool will be provided to the		
	04/18/11 at 1:00	P.M., and indicated			Director of Nursing for input	as to	
	Resident #23 use	ed Lortab 7.5-500 fifteen			the effectiveness. This information will be discussed		
	times in 24 days	as follows:			quarterly with the Quality		
	02/03/11 at 8:00				Improvement Committee. Th	ne	
	02/04/11 at 7:30 A.M. and 8:00 P.M. for				MDS Coordinator will update		
	"lower back pain."  02/05/11 at 8:00 A.M. for "bilateral knee				pain assessment and evalua		
					pain medication use for the la		
					90 days (using the quarterly	paın	
	pain."	D. C. 1111 ( 11			evaluation form) for effectiveness. The Director of	of	
	02/05/11 at 8:00	P.M. for "bilateral knee			enectiveness. The Director (	JI	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155520	A. BUI		00	04/20/2011
		100020	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	04/20/2011
NAME OF I	PROVIDER OR SUPPLIER				RST AVE	
CORE N	URSING & REHABI	LITATION		1	VILLE, IN47710	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
	pain." 02/09/11 at 8:45 moaning." 02/12/11 at 8:00 pain." 02/13/11 at 8:00 pain." 02/19/11 at 8:00 pain." 02/20/11 at 8:00 pain." 02/21/11 at 9:00 pain."	P.M. for "bilateral knee P.M. for "rubbing knees P.M. for "bilateral knee P.M. for "bilateral knee P.M. for "bilateral knee P.M. for "bilateral knee A.M. for "bilateral knee			Nursing assumes responsible and will monitor weekly through the monitoring tool provided each Unit Manager. This monitoring will become particle weekly at-risk meeting agent and will be ongoing for the remainder of 2011.	ugh by of the
	moaning. Asked 02/23/11 at 8:00	A.M. for "rubbing knees if in pain states 'yeah.'" P.M. for no reason				
	pain."	P.M. for "bilateral knee				
	02/27/11 at 8:00 pain."	P.M. for "bilateral knee				
	04/18/11 at 1:00	MAR was reviewed on P.M. and indicated				
	times in 24 days	ed Lortab 7.5-500 fifteen on:				
	· ·	A.M. and 8:00 P.M. for				
	bilateral knee pai	in.				
	03/06/11 at 8:00	A.M. and 8:00 P.M. for				
	"bilateral knee pa	ain."				
		A.M. for "knee pain."				
	03/09/11 at 8:00	P.M. for "knee and leg				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					INSTRUCTION 00	(X3) DATE S COMPL	
		155520	A. BUI			04/20/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				RST AVE		
CORE N	URSING & REHABI	LITATION			VILLE, IN47710		
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PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	pain."						
		P.M. for "knee and leg					
	pain."						
	03/12/11 at 8:00	P.M. for "knee pain."					
	03/13/11 at 8:00	P.M. for "knee pain."					
	03/14/11 at 7:45	P.M. for "knee pain."					
	03/19/11 at 8:00	P.M. for "knee pain."					
	03/20/11 at 8:00	P.M. for "knee pain."					
	03/21/11 at 8:45	A.M. for "rubbing knees					
	and moaning."	_					
	03/22/11 at 9:00 A.M. for "knee pain."						
		A.M. for "bilateral knee					
	pain."						
	1 ^	P.M. for "bilateral knee					
	pain."						
	1 ^	P.M. for "bilateral knee					
	pain."	1.1VI. 101 Unateral Rife					
	pani.						
ı	The April 2011 N	MAR was reviewed on					
	04/18/11 at 1:00	P.M. and indicated					
	Resident #23 use	ed Lortab 7.5-500 eleven					
	times in 15 days						
	1	A.M. for "moaning					
	loudly suspect pa	•					
		P.M. for "knee pain."					
		A.M. for "moaning					
	loudly as in pain.	_					
	1 1	A.M. for "bilateral knees					
	hurting."	TOT OTHER MILES					
		5 P.M. for "rubbing knees					
	and moaning."	7 1.111. 101 Tuooning Kiices					
	_	P.M. for "rubbing					
	knees."	1 .1v1. 101 Tuoonig					
		D.M. for "Irnoa main "					
	U4/U9/11 at 8:00	P.M. for "knee pain."					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155520	B. WIN	G		04/20/20	011
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI EIER			1	RST AVE		
CORE N	URSING & REHABI	LITATION		EVANS	VILLE, IN47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	<b>1</b>	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		P.M. for "knee pain."					
		A.M. for "bilateral knee					
	pain."						
		P.M. for "moaning, knee					
	pain."						
		P.M. for "moaning					
	rubbing knees."						
		nent, provided by LPN					
	-	cal Nurse] #3 on 04/18/11					
		d identified by LPN #3 as					
	a worksheet and						
		I not been experiencing					
	l ^	days, with a handwritten					
	notation, "states '	no.'"					
		lication the LPN had					
		ident's regular use of prn					
	_	for pain, or evaluated the					
		of routine pain medication					
		aily use of as needed pain					
	medication.						
	The Deller on 1 P	han and hama from De ha					
	1 -	Procedure for Pain					
	"	ovided by the DoN on					
		P.M., indicated, "All					
		ssessed for pain control					
	1 -	ssion and quarterly					
		ng the Pain Assessment					
	,	s) pain management					
		eness will be evaluated					
		e MDS coordinator.					
	1 '	OS coordinator will					
	update the pain a	ssessment and review					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN		ISTRUCTION  00	(X3) DATE S COMPL		
		155520	B. WING		<u> </u>	04/20/2	011
	PROVIDER OR SUPPLIER		90	09 FIRS	DDRESS, CITY, STATE, ZIP CODE ST AVE 'ILLE, IN47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
	3.1-31(a)	use for the last 90 days."					
F0282 SS=D	facility must be proin accordance with plan of care. During observation review, the facility resident who require for transfers was the plan of care, it transferred from commode without lift, for 1 of 1 suppresident in the sup	pplemental sample pplemental sample of 1 pple	F0282	2	This facility will ensure any resident requiring a mechanic lift for transfers is transferred according to their plan of care. Resident #23 was evalu for physical function on April 2011 and it was determined the requires a mechanical lift all transfers to assist in pain reduction/management of bi-laterlal knee pain. CNAs vinserviced on may 6, 2011 or importance of the resident cainformation sheet and folloiw the resident's plan of care communicated via the CNA Assignment sheet. All resident utilizing a mechanical lift for transfers were reviewed. The care plans, CNA Assignment Sheet, Resident Care Informations Sheet were reviewed for account consistency. Interviews CNAs along with actual visual checks were performed to determine the mechanical lift being utilized for all transfers was determined there were nother residents negatively	ated 26, hat for vere n the ire ng ts eir ation uracy with il was . It	05/20/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155520		A. BUILDI		NSTRUCTION 00	(X3) DATE S COMPL 04/20/20	ETED	
	PROVIDER OR SUPPLIER		9	909 FIR	DDRESS, CITY, STATE, ZIP CODE ST AVE //ILLE, IN47710	0 1/20/2	
(X4) ID PREFIX TAG	ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  and osteoporosis.  Resident #23 was observed, on 04/18/11 at 10:00 A.M., being transferred from a wheelchair to a commode by CNA [Certified Nursing Assistant] #1 and CNA  ID PROVIDERS IN PROVIDERS IN PROVIDERS IN PROFIX AMAY 6, 2011 the resident sheet and the sheet a				PROVIDERS PLAN OF CORRECTION GACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  affected.CNAs were inserviced on May 6, 2011 on the importance of the resident care information sheet and the CNA Assignment sheet. A daily monitoring form has been developed to assist the charge nurse in monitoring all		
	#2 using a gait be sling was noted uthat time.  The most current Set Assessment], indicated that Re cognitively impadependent for toil	elt. A mechanical lift underneath the resident at EMDS [Minimum Data dated 02/24/11, sident #23 was severely ired, was completely let use, personal hygiene, motion limitations to the			residents requiring a mechan lift for transfers to ensure the being utilized for all transfers. The charge nurse will monitor daily for compliance with each resident requiring a mechanilift for transfers. This complemonitoring tool will be given Director of Nursing weekly for review. Residents requiring mechanical lift will be discus weekly with the IDT member at-risk meeting. The charge nurse will monitor daily for the first three (3) months and the	chanical the lift is fers. nitor each canical npleted en to the y for ing a cussed bers rge or the	
	02/23/11, indicat "dependent for all A Care Plan, upd "Self-care deficit physical and cog endurance to acti staff with all tran mechanical lift for transfersAppro 2 et[and] use of a transfers"  A Resident Care	ated on 02/15/11, for r/t [related to] decreased nitive ability et vity with dependence on sfers/mobility. Use of or aches13. Staff assist of mechanical lift with all	weekly for the re 2011. The Direct assumes respon utilize the mech monitoring tool t Quality Improve at least quarterly residents require mechanical lift fo		weekly for the remainder of 2011. The Director of Nursing assumes responsibility and vuilize the mechanical lift monitoring tool to report to the Quality Improvement Commat least quarterly to ensure the residents requiring the use of mechanical lift for transfers a being transferred according their plan of care established that resident.	will ne ittee nat all f a are to	
		5/11, indicated Resident					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/S			(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE SUR COMPLETI	
ANDILAN	or connection	155520	A. BUI			04/20/201	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				RST AVE		
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IAG	#23 required a m	,		IAG	,		DAIL
	1 ^	s non-ambulatory."					
	A Nursing Progra	ess Note, dated 04/12/11					
	1	dicated "up daily in					
	•	mechanical lift for					
	transfers"						
	An ADL [Activit	y of Daily Living]					
	Functional/Resto	rative Assessment dated					
	02/15/11 indicate	ed Resident #23 had no					
	1 ~ ~	bility to the Right or Left					
	leg and required	a Hoyer lift for transfers.					
	An attendance ro	ster for an inservice					
	covering "ROM	[Range of Motion], Gait					
	training, Body M	lechanics" was provided					
	by the ADoN [As	ssistant Director of					
	Nursing] on 04/1	8/11 at 5:05 P.M. and					
	indicated CNA#	1 and CNA #2 attended					
	on 09/10/10. The	e inservice education					
	1 *	ut was not limited to,					
		on transfer when a					
	1 *	50% weight bearing.					
		transfers have been used					
	_	is non-weight bearing,					
	but this is not rec	commended"					
	The Policy and P	rocedure for "Using a					
		vice" [no date] was					
	provided by the I	-					
	1	8/11 at 5:43 P.M. and					
		ose: The purpose of using					
	a portable lift dev	vice is to help lift resident					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155520		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	TE SURVEY  IPLETED  1/2011	
	PROVIDER OR SUPPLIER		909 FIR	ADDRESS, CITY, STATE, ZIP C RST AVE VILLE, IN47710	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
		ght bearing, dependent le to move themselves"				
	RN #1 on 04/12/indicated Resider careincontinent mechanical lift for In an interview wat 11:00 A.M., she [sic] should be grincontinent, after and when we chause the lift in the In an interview wat 11:45 A.M. she [Resident #23] was morning. They do him on the commuses the lift in the In an interview wat 12:00 P.M., she	nt #23 required "total to bowel and bladder, for transfers".  with CNA #2, on 04/18/11 the indicated, "Peri-care iven if they are they use the bathroom, ange them."  with CNA #1 on 04/18/11 the indicated, "We get him with the lift in the on't use the Hoyer to put mode. The second shift the evening."  with RN #1, on 04/18/11 the indicated, "We don't the evening the with the lift in the on't use the Hoyer to put mode. The second shift the evening."				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155520		A. BUILDING 00 COM				PLETED	
		100020	B. WIN		A DDDDGG GITTY GTATE TIN CODE	04/20/2	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
	JRSING & REHABI				VILLE, IN47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F0312 SS=D	of daily living recei to maintain good n personal and oral	unable to carry out activities ives the necessary services outrition, grooming, and hygiene.  ation, interview and	F0	312	This facility will ensure that		05/20/2011
		e facility failed to ensure			residents who are unable to carry		
		ere dependent on staff for			out activities of daily living re	ceive	
		, were provided thorough			the necessary services to maintain good nutrition,		
		owing incontinence, for 1			grooming, and personal and	oral	
	of 5 sampled dep	,			hygiene. Ensuring resident(s		
		ontinence (Resident #77),			who are dependent upon sta		
		le of 15, and for 1 of 1	, I here		personal hygiene, were provi		
	_				thorough perineal care follow incontinence.CNAs #1, #2, #		
		nple resident reviewed			received written disciplinary	J, #U	
		care, in the supplemental			action for not following policy	and	
	sample of 1 (Res	ident #23).			procedure in providing prope		
					perineal care for a dependen		
	Findings Include	:			resident. CNAs were inservi on May 6, 2011 on the prope		
					procedures of performing per		
	_	tour, on 04/12/11 at 1:15			care following incontinence.		
		icated Resident #23 was			inservice will include, but not		
	not interviewable	*			limited to, step-by-step perind	eal	
		re, and was transferred by			care for male and female residents, return demonstrati	on	
	Hoyer [mechanic	eal] lift.			and the use of universal	OII	
					precatutions to prevent the		
	The clinical reco	rd of Resident #23 was			spread of infection. An inser		
	reviewed on 04/1	8/11 at 10:30 A.M.			for full-staff was held on April		
	Resident #23's di	agnoses included, but			2011 on the importance of pr handwashing. A monitoring		
	were not limited	to, Alzheimer's, arthritis,			was developed for each CNA		
	and osteoporosis.	-			perform a return-demonstrati		
	_				for providing proepr perineal		
	Resident #23 was	s observed on 04/18/11 at			for a dependent resident. The		
		g assisted to the toilet.			monitoring tool allows each ( three (3) return demonstratio		
	Resident #23 was				The Director of Nursing or he		
	incontinent of uri				designee will ensure that each		
	moonthion of an				CNA can demonstrate proep	r	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		ĺ	ULTIPLE COI LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155520	B. WIN	G		04/20/2011
	PROVIDER OR SUPPLIER		•	909 FIR	DDRESS, CITY, STATE, ZIP CODE ST AVE VILLE, IN47710	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	step-by-step perineal care th	DATE
		ef to be changed. CNA			their male and female	ieii
		were observed to provide			resident(s). This monitoring	tool
		care to Resident #23, i.e.			will also be utilized in the fut	ure
	_	he skin in contact with			for newly hired CNAs to ens	
	the urine.				they can demonstrate prope perineal care. There were no	
					residents negatively affected	
		MDS [Minimum Data			this practice, although all	· ~,
	Set Assessment],	dated 02/24/11,			incontinent residents had the	e
	indicated Resider	nt #23 was severely			potential to be affected. The	
	cognitively impa	ired, was always			perineal care policy and	
	incontinent, was	completely dependent for			procedure has been updated inservice for all CNAs was h	1
	toilet use, and pe	rsonal hygiene.			on ay 6, 2011 on the proper	eiu
		, ,			step-by-step procedures of	
	A Care Conferen	ce Summary, dated			performing perineal care for	
		ed Resident #23 was			and female residents. To pa	ass,
	"dependent for all				one successful return	
		ii care.			demonstration for both a fen and male resident out of thre	
	A Como Diam sum d	oted on 02/15/11 for			attempts are required by each	` '
		ated on 02/15/11, for			CNA for the Director of Nurs	
		r/t [related to] decreased			her designee. (i.e., The CN	
	physical and cog				must pass two (2) of the three	· · ·
	Dependent for hy				attempts one (1) being mand one (1) being female in	
		nent of Bowel and			to remain employed in this	
		f monitoring every 2			facility). The monitoring too	will
	1 * *	needed] with hygiene			be utilized on each newly him	red
	_	eatedApproaches18.			CNA to ensure they can	
		for incontinence every 2			demonstrate proper perinea for both the male and female	
		d provide hygiene as			resident.The Director of Nur	· I
	indicated."				assumes responsibility for	9
					compliance and will have ea	
	A Resident Care	Information Form,			CNA return demonstrate pro	· I
	updated on 04/05	5/11, indicated Resident			step-by-step perineal care the	
	1 ^	nent of urine and			(3) times. Should the CNA to unable to return demonstrate	
	stoolprovide pe				successfully three (3) times,	
	incontinence."	[]			employment will be terminat	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155520	A. BUI	LDING	00	04/20/2011	
		100020	B. WIN		DDDEGG CITY OTHER TIN CODE	0-1/20/2011	ᆜ
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
CORE N	URSING & REHABI	LITATION		1	VILLE, IN47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	$\dashv$
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG		DATE	_
TAG	A Nursing Progret at 10:00 P.M., into bowel and bladded by staff."  The CNA Assign RN #1 on 04/12/indicated Resider careincontinent 2. On 11/18/11 at and #6 were observed incontinent of bowet wash cloths the wore gloves and buttocks and periode and the area at under the resident resident onto her at that time, CNa check the resident CNA #6 then obtaind wet them and	ess Note, dated 04/12/11 dicated, "incontinent of er with peri care provided		TAG	This monitoring tool will be utilized by the Director of Nu or her designee on all new h to ensure that all CNAs can demonstrate proper perineal care. This monitoring will be ongoing. The Director of Nu will report her monitoring of perineal care to the Quality Improvement Committee at I quarterly. She will follow any recommendations that might made. The perineal monitori tool will be maintained by the Director of Nursing.	rsing ires  rsing  east be ng	
		highs and periarea. She					
	was observed to	wash forward and back					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLI	
ANDILAN	OF CORRECTION	155520	A. BUII		00	04/20/20	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				RST AVE		
	URSING & REHABI			1	VILLE, IN47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		rinary catheter, removing		IAG	,		DAIL
	brown soil from	, ,					
	orown son nom	the resident.					
	Following the pro	ocedure, CNA #6 took					
	her gloves off an	d left the room. She was					
	then questioned r	regarding the wash					
	cloths. She indic	eated she had wet them					
	with water and ha	ad not put any soap or					
	periwash solution	n on the wash cloths.					
	1 2	d procedure for Perineal					
		as provided by the					
		es on 4/18/11 at 5:40 p.m.					
		rocedure included, but					
	was not limited to	o, the following:					
	"Perineal care for	r female patients:					
		h, dry towel(s) soap or					
	periwash and bat						
	•	n with clean water at 110					
	degrees,	ii widi cicali water at 110					
		a and wash, rinse and dry					
	the urethral area	-					
	downward stroke	es alternating from side to					
		ing until the exposed area					
	around the urethr	-					
	-wash the groin o	on the outside of the labia					
	from the front to	the back starting outside					
	the labia and ther	n going to the inside of					
	the thighs,						
	-turn the person of	on their side,					
		and dry the rectal and					
	buttock area."						

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155520		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	l` ´	E SURVEY PLETED /2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  909 FIRST AVE  EVANSVILLE, IN47710					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
	covering "Incont by the ADoN [A Nursing] on 04/1 indicated CNA # the inservice on education piece ilimited to, "Wipo In an interview wat 11:00 A.M. sh [sic]should be gi	vith CNA #2 on 04/18/11 e indicated, "Peri-care ven if they are they use the bathroom,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155520	B. WING		04/20/2011
	PROVIDER OR SUPPLIER  URSING & REHABII		909 FIF	ADDRESS, CITY, STATE, ZIP CODE RST AVE SVILLE, IN47710	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0441 SS=E	Infection Control P a safe, sanitary an and to help preven transmission of dis  (a) Infection Control The facility must exprogram under wh (1) Investigates, coinfections in the fac (2) Decides what p isolation, should be resident; and (3) Maintains a recorrective actions (b) Preventing Spr (1) When the Infect determines that a prevent the spread must isolate the re (2) The facility must communicable disc lesions from direct their food, if direct disease. (3) The facility must hands after each di	stablish an Infection Control lich it - controls, and prevents cility; brocedures, such as e applied to an individual cord of incidents and related to infections.  lead of Infection ction Control Program resident needs isolation to d of infection, the facility sident. let prohibit employees with a lease or infected skin			
	professional practi	ng is indicated by accepted ce.			
	transport linens so infection. Based on observa record review, the	andle, store, process and as to prevent the spread of ation, interview and e facility failed to ensure a provided in a manner to	F0441	This facility has established a infection control program designed to provide a safe, sanitary and comfortable	an 05/20/2011
		infections, and failed to are changed and hands		environment and to help prev the development and	/ent

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
155520		A. BUI	LDING	00	04/20/2		
		133320	B. WIN			04/20/2	011
NAME OF	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
CODE N	LIDOING & DELIAD	II ITATION		1	STAVE		
	URSING & REHAB			EVANS	VILLE, IN47710		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	·		DATE
		ween soiled and clean			transmission of disease and infection. The facility ensures	that	
	1	g care observations for 3			perineal care is provided in a		
	of 13 sampled re	esidents, in the sample of			manner to prevent potential	•	
	15, and for 1 of 1	l supplemental sample			infections, and ensures glove	es	
	resident, in the s	upplemental sample of 1,			are changed and hands are		
	in that perineal c	are was not thoroughly			washed between soiled and		
	_	was provided in a manner			activities.CNAs were inservice on may 6, 2011 on Infection	cea	
	1 ~	infection, and CNAs			Control and the need to prov	ide	
		provide care and not			perineal care in a manner to		
	change gloves and wash hands when potentially contaminated. (Residents #65, #77, #9, #23)				prevent potential infections a	ind	
					ensure that gloves are chang		
					and hands are washed between		
					soiled and clean activities. T		
					ensure that any equipment (i over-the-bed table) used will		
	Findings include	): 			thoroughly cleaned after peri		
					care or bathing.CNAs #1, #2		
		t 9:10 a.m., CNA 6 was					
	_	ing a bed bath to Resident	action for not following policy and procedure in providing proper perineal care for a dependent				
	#65. The bath w	vater was in a wash pan on					
	the overbed table	e. During the cleansing of	resident. CNAs were inserviced				
	the front perinea	l area, the CNA washed		on May 6, 2011 on the proper			
	and rinsed from	the back to the front.			procedures of performing pe		
	When the bath w	vas completed, the CNA			care following incontinence.		
		sin off of the overbed			inservice included step-by-st	-	
	table and emptie	d the water. There was			perineal care for male and fe residents, return demonstrati		
	1	ater on the overbed table.			and the use of universal		
		oned the resident, covered			precautions to prevent the sp	oread	
	1	room without sanitizing			of infection. An inservice for		
	the overbed table	<del>-</del>			full-staff was held on April 22	2,	
	life overbed table	J.			2011 on the importance of handwashing to prevent the		
	On 4/19/11 at 2:	20 n m the observation			spread of infection. A monitor	orina	
		30 p.m., the observation			form was developed for each		
		th the Director of Nurses.			CNA to perform a return		
		e CNAs should be			demonstration for providing		
	_	erbed table if soiled with			proper perineal care for a		
	bath water.				dependent resident. This		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER: A. BU		LDING	00	COMPLETED
		155520	B. WIN			04/20/2011
(F oF r			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF I	PROVIDER OR SUPPLIE	К		909 FIR	RSTAVE	
CORE N	URSING & REHAB	ILITATION		1	VILLE, IN47710	
(X4) ID	CUMMADV	STATEMENT OF DEFICIENCIES		ID		(V5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
IAG	REGULATORT OF	CESC IDENTIF TING INTOKWATION)		IAG	monitoring tool allows each	
					three (3) return demonstration	
		t 11:45 a.m., CNAs #6			The Director of Nursing or h	• • • • • • • • • • • • • • • • • • •
	and #5 were obs	erved repositioning			designee will ensure that ea	• • • • • • • • • • • • • • • • • • •
	Resident #77. T	he resident had an			CNA can demonstrate prope	
	indwelling urina	ry catheter. She had been			step-by-step perineal care for	o
		owel. CNA #5 was			rtheir male and female resid	ents.
	1	r gloves; she cleansed the			This monitoring tool will also	
					utilized for all newly hired C	• • • • • • • • • • • • • • • • • • •
		ks and anal area by			to ensure they can demonst	
		reral times from the area.			proper perineal care. There no other residents affected l	
	After she used w	vet wash cloths to wipe			practice, however all resider	·
	the back side of	the resident, she held the			had the potential to be	11.5
	residents hand w	with the same gloved hand			affected.The perineal care p	oolicy
	used to cleanse the resident and assisted				and procedure has been	
		irn onto her back. She			updated. An inservice for a	I I
					CNAs was held on May 6, 2	011
	1	oves off and used alcohol			on the proper step-by-step	
	1 -	giene. She covered up the			procedures of performing pe	erineal
	resident and was	s prepared to leave the			care for male and female	
	room. At that ti	me, it was requested that			residents. Three (3) return	1 6
	she check the fro	ont perineal area. She			demonstrations are required each CNA for the Director o	· 1
	uncovered the re	esident and checked. She			Nursing or her designee. The	I
	l then used wet w	ash cloths to remove			monitoring tool will be utilize	• • • • • • • • • • • • • • • • • • •
		om the front area. She			each newly hited CNA to en	
					they can demonstrate prope	
		wipe back and forth over			perineal care for the male a	nd
		und the catheter, with			female resident. The Directo	
	potential for con	tamination of the area.			Nursing assumes responsib	
					for compliance and will have	• • • • • • • • • • • • • • • • • • •
		ith the repositioning and care of			CNA return demonstrate pro step-by-step perineal care for	
		vas observed to remove her			their male and female reside	
	~	room. She went to the nurses'			Should the CNA be unable to	
		d some over the counter			return demonstrate success	
		N #2's personal supply; the in her hand. She then went to			three (3) times, their employ	
	_	me water. At that time, she was			will be terminated. This	
		rashing her hands. She			monitoring tool will be utilize	
	l ^	d after she took the medication.			the Director of Nursing or he	
	marculed sile would	a area one took the medication.			designee on all newly hired	CNAS
FORM CMS-2	2567(02-99) Previous Versi	ons Obsolete Event ID:	NNBY11	Facility l	ID: 000437 If continuation	sheet Page 26 of 33

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155520		A. BUILDIN		NSTRUCTION  00	(X3) DATE S COMPLI <b>04/20/2</b> (	ETED	
NAME OF PROVIDER OR SUPPLIER  CORE NURSING & REHABILITATION			90	09 FIRS	DDRESS, CITY, STATE, ZIP CODE ST AVE //LLE, IN47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	She was also questic had provided to CN. #77. She indicated swater and had not us them.  Resident #77's clinic 4/13/11 at 1:50 p.m. been treated for a ur on 4/1/11.  3. During initial P.M. RN #1 indicated assistance for car Hoyer lift.  The clinical recorreviewed on 04/1 Resident #23's diwere not limited and osteoporosis  Resident #23 was 10:00 A.M. being wheelchair to a car [Certified Nursin #2 using a gait be Resident #23 was incontinent of urincontinence brief and CNA #2 were incontinence care.	oned about the wash cloths she A #5 for cleansing Resident she had just wet them with sed any soap or periwash on  The record was reviewed on The record indicated she had inary tract infection, starting  tour on 04/12/11 at 1:15 cated Resident #23 was e, required total re, and was transferred by  rd of Resident #23 was 8/11 at 10:30 A.M. agnoses included, but to, Alzheimer's, arthritis, s observed on 04/18/11 at g transferred from a ommode by CNA g Assistant] #1 and CNA elt. s observed to be			to ensury they can demonstrate proper perineal care and universal precautions. This monitoring will be ongoing. To Director of Nursing will report monitoring of infection control the Quality Improvement Committee at least quarterly follow any recommendations made.	Γhe t her ol to and	
		v=,= ,, 11 maioutou					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER  CORE NURSING & REHABILITATION  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 909 FIRST AVE EVANSVILLE, IN47710  (X5)	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
NAME OF PROVIDER OR SUPPLIER  CORE NURSING & REHABILITATION  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES PREFIX  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  STREET ADDRESS, CITY, STATE, ZIP CODE 909 FIRST AVE EVANSVILLE, IN47710  (X5) PREFIX  PREFIX  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  PREFIX  COMPLETION  COMPLETION	AND PLAN	OF CORRECTION				00	1	
NAME OF PROVIDER OR SUPPLIER  CORE NURSING & REHABILITATION  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH DEFICIENCED TO THE APPROPRIATE COMPLETION COMPLETION CROSS-REFERENCED TO THE APPROPRIATE			100020	B. WIN		A DDDEGG CITY GTATE ZID CODE	04/20/2	
CORE NURSING & REHABILITATION  EVANSVILLE, IN47710  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION	NAME OF PROVIDER OR SUPPLIER							
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION	CORE N	URSING & REHABI	LITATION		1			
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DDOVIDED'S DLAN OF CODDECTION		(X5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DATE	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
	TAG				TAG	DEFICIENCY)		DATE
that Resident #23 was severely			•					
cognitively impaired, was always		" '	•					
incontinent, was completely dependent for		I						
toilet use, personal hygiene, and transfers.		toilet use, person	al hygiene, and transfers.					
A Care Conference Summary dated		A Care Conferen	ce Summary dated					
02/23/11 indicated, Resident #23 was			•					
"dependent for all care."		"dependent for al	ll care."					
A Care Plan updated on 02/15/11 for		A Care Plan unda	ated on 02/15/11 for					
"Self-care deficit r/t decreased physical		1						
and cognitive ability et endurance								
Dependent for hygiene and			-					
bathingIncontinent of Bowel and		· •						
bladder with staff monitoring every 2		_						
hours and prn [as needed] with hygiene								
provided as indicatedApproaches18.		provided as indic	catedApproaches18.					
Staff to monitor for incontinence every 2		Staff to monitor t	for incontinence every 2					
hours and prn and provide hygiene as		hours and prn and	d provide hygiene as					
indicated."		indicated."						
A Resident Care Information Form		A Resident Care	Information Form					
updated on 04/05/11 indicated, Resident								
#23 was "incontinent of urine and			<i>'</i>					
stoolprovide pericare after								
incontinence".								
A Nursing Progress Note date 04/12/11 at		-						
10:00 P:.M. indicated, "incontinent of			· ·					
bowel and bladder with peri care [sic]								
provided by staff."		provided by staff	2 II 					
An attendance roster for an inservice		An attendance ro	oster for an inservice					
covering "Incontinent Care" was provided								

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

<b> </b> 155520				ONSTRUCTION 00	(X3) DATE S COMPL		
		A. BUII B. WIN	011				
	PROVIDER OR SUPPLIER URSING & REHABI			STREET A	ADDRESS, CITY, STATE, ZIP CODE RST AVE VILLE, IN47710		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
IAU	by the ADoN [As Nursing] on 04/1 indicated CNA # the inservice on 0 education piece i limited to, "Wipe The CNA Assign RN #1 on 04/12/ Resident #23 req careincontinent mechanical lift for In an interview wat 11:00 A.M. should be given in after they use the change them."  4. During initial P.M., RN #1 indinot interviewable assistance for care bladder.  The clinical reconverse on 04/1 Resident #9's dia were not limited Disease and Dem Resident #9 was 9:45 A.M. being	ment Sheet provided by 11 at 1:15 P.M. indicated uired" total t bowel and bladder, or transfers".  with CNA #2 on 04/18/11 e indicated, "Peri-care of they are incontinent, bathroom, and when we  tour, on 04/12/11 at 1:20 icated Resident #9 was e, required total re, and was incontinent of  rd of Resident #9 was 8/11 at 9:45 A.M. gnoses included, but to, Chronic Kidney		IAU			DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED			
		155520	B. WING 04/20/2011					
NAME OF F	PROVIDER OR SUPPLIER	- L		1	ADDRESS, CITY, STATE, ZIP CODE			
CODE N	LIDOINIO & DELLADI	LITATION		1	RST AVE			
	URSING & REHABI				VILLE, IN47710			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X		
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPL:		
IAG			+	IAU	Dia relative 17	DAI	E	
	l <sup>-</sup>	ng Assistant] #1 and CNA  3 was observed to void						
		ommode. CNA #1 was						
	_	ride perineal care to the						
		tal area without providing						
	permear care to t	he front perineal area.						
	The most surrent	t MDS [Minimum Data						
	Set Assessment],	-						
	]	esident #9 was severely						
		ired, was completely						
	dependent for toilet use, personal hygiene, and transfers.							
	and transicis.							
	A Care Plan und:	ated April 2011 for						
	1	t r/t decreased physical						
		ilityDependent for						
		aches2. Shower two						
	''	d prn [as needed]."						
	times a week and	i pini [us needed].						
	A Resident Care	Information Form,						
		5/11, indicated the staff						
	would provide pe							
	In an interview w	vith CNA #2, on 04/18/11						
		ne indicated, "Peri-care						
	· ·	if they are incontinent,						
		e bathroom, and when we						
	change them."	The state of the s						
	5. The policy and p	rocedure for Perineal Care [no						
		by the Director of Nurses on						
		The purpose included: "To						
	cleanse the perineal	area after urination or a bowel						
	L							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		INSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
	155520		B. WIN	011			
	PROVIDER OR SUPPLIER		· •	909 FIR	ADDRESS, CITY, STATE, ZIP CODE RST AVE VILLE, IN47710	!	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  movement to minimize the chance of infection, irritation or discomfort."  Perineal care for female patients included, but was not limited to, the following: "Separate the labia and wash, rinse and dry the urethral area first with short downward strokes alternating from side to side and proceeding until the exposed area around the urethra is done"  Also included in the policy and procedure: "Hands will be washed before and after procedure." "Clean bedside area as indicated." "Wash hands."			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	date] was provided by 4/18/11 at 5:40 p.m. included, but was no "Appropriate fifteen handwashing with so performed under the "After contact with by secretions, mucous or After handling items blood, body fluids, each After removing glow Whenever in doubt						
F0458 SS=E	feet per resident in	least 100 square feet in					

	NT OF DEFICIENCIES  OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155520		LDING G	00	04/20/2	LETED
NAME OF PROVIDER OR SUPPLIER  CORE NURSING & REHABILITATION				909 FIR	ADDRESS, CITY, STATE, ZIP CODI RST AVE VILLE, IN47710	3	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	record review, the provide 80 square resident in multifor 9 of 43 resident nursing units (Resident residents current for 10, 111, 112, 112). That the potential residents current for 109, and *110 two residents in observed on 4/20. According to the form maintained measured 145.12 Each room was of care. Each reference 2. Resident room *114 were observed on 4/20/11 at 1:30 per room size certification measure 145.12 Each room was care. Each residents in each 4/20/11 at 1:30 per room size certification was care. Each residents in each 145.12 Each room was care. Each residents for 145.12 Each room was care.	ns *106, *107, *108, were observed set up for each room, when 0/11 at 1:30 p.m. e room size certification by the facility, the rooms 2 square feet per room. certified for SNF/NF level sident bed had a total of t.  m *111, *112, *113, and ved set up for two a room, when observed on o.m. According to the cation form, the rooms square feet per room. certified for NF level of ent bed had a total of	FO	458	A room size variance has requested from the India Department of Health of 2011 for rooms 106, 107, 109, 110 which are dual and Rooms 111, 112, 11 which are NF.There were residents negately affect their room size. The Adn and Director of Nursing continue to monitor daily ensure compliance and all residents.	ana State n April 27, 7, 108, ly certified 3, 114 re no ted by ninistrator will y to	05/20/2011

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155520	(X2) MULTIPLE CO  A. BUILDING  B. WING	00		e survey pleted /2011		
NAME OF PROVIDER OR SUPPLIER  CORE NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE  909 FIRST AVE  EVANSVILLE, IN47710					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
	currently had roo	nce with the ne indicated the facility om size waivers and they through the upcoming						